Medical Record
Resident Mrs. Louise Grant

The surveyor came to review this case because the resident was identified in the sample as someone with dementia on an antipsychotic medication.
The surveyor first identifies a story about this resident, using the following sources of information:

- *Hospital discharge summary*
- *Social services history and notes*
- *Physician order sheets*
- *RAI*
- *Consultant pharmacist monthly drug regimen reviews*
- *Nurses notes*
- *Behavior documentation sheets*
- *Activities Notes*
- *Physician/NP/PA/CNS Progress notes*
- *Care plans*
- *Medication Administration Record*

Background

Hospital Discharge Summary (from Mrs. Grant's original admission to the facility 14 months ago): Mrs. Louise Grant, a 78-year-old Caucasian woman, had been living at home with her daughter until she developed influenza. Because she was having difficulty keeping fluids down, she was admitted to the hospital for three days of short-term treatment and monitoring. During hospitalization, fluid and electrolyte balance were restored. She was then admitted to Stone Valley Manor Nursing Home for long-term care, as her cognition, function and safety awareness had been declining to the point that her daughter could no longer care for her at home.

On admission to the nursing home, her diagnoses included: influenza, dehydration, history of mild CHF, dementia, and arthritis. Hospital discharge medications included: Acetaminophen (Tylenol Extra Strength) one 500 mg tablet every 6hours as needed for generalized arthritis pain (not to exceed 3 grams per day); Quetiapine (Seroquel) 50 mg po bid; oxybutinin (Ditropan) 5 mg po three times a day; lansoprazole (Prevacid) 30 mg po daily; digoxin (Lanoxin) 0.125 mg po daily; MVI one po daily; Colace one tab po tid, and lorazepam (Ativan) 0.5 mg q8h prn.

<u>All remaining documents are from Stone Valley Manor:</u>
Social Services: [Resident history, as provided by resident's daughter, was documented in the Social Worker's notes.]
Resident Louise Grant is a 78-year-old Caucasian female who has resided at Stone Valley Manor for the past 14 months. Mrs. Grant had been living at home with her daughter until she developed the flu. After being hospitalized for treatment, she was admitted to the nursing home for long-term care because her safety awareness due to limited cognition made it impossible for the family to continue to care for her at home.

Her diagnoses include osteoarthritis, a history of mild congestive heart failure, and dementia. Surgical history includes an uncomplicated right knee replacement for osteoarthritis 12 years ago. Most recently she is described as alert and oriented to self but

not usually to time or place. She does not wear dentures and currently has no chewing or swallowing problems. She wears glasses to correct nearsighted vision. She has difficulty expressing her needs. She calls out at times but is often unable to articulate what she might want or need. She is sometimes understood when expressing ideas and wants. She sometimes understands others. She is often incontinent.

Mrs. Grant was raised with five siblings by her parents in a rural setting. Upon graduating from high school, she went to a metropolitan area where she earned her Bachelor's degree in Education. She married and had two children, a son and a daughter. Mrs. Grant worked as an assistant in a real estate office throughout her career.

While growing up, she enjoyed outdoor activities. Although she spent her adult life in the city, she maintained her love of nature. She enjoyed gardening and being outdoors. She enjoyed reading books and watching some movies but she was never an avid television watcher. Attending public religious services every week also remained important to her. She did not play any musical instruments, but she loves listening to music and sounds of nature on her favorite CDs.

Mrs. Grant and her husband lived together until he passed away 2 years ago. She then lived with her daughter until being admitted to the facility. Her grown son currently lives on the other side of the country with his wife and children. Her grown daughter, Joanna Castle, lives in the same town in which the nursing home is located. Her daughter is married, works full time, and has young children of her own. Mrs. Grant's daughter visits her at the facility at least once every weekend and usually once during the week. She is her mother's financial and durable power of attorney for health care.

Current Physician Orders:
At the time of the survey, the current medications included: lansoprazole (Prevacid) 30 mg po daily, MVI daily, colace one tab po tid, Acetaminophen (Tylenol Extra Strength) one 500 mg tablet every 6 hours as needed for generalized arthritic pain not to exceed 3 grams in 24 hours; oxybutinin (Ditropan) 5 mg by mouth three times a day; Quetiapine (Seroquel) 75 mg po bid, and lorezepam (Ativan) 0.5 mg q8h prn, not to exceed 2mg in a 24 hour period. The orders also included participation in the Walk to Dine Program twice a day, seven days a week.

RAI: MDS/CAAs/CATs/Care Plan: Review of the Annual and Quarterly RAI Assessments indicated that Mrs. Grant wears glasses to correct nearsighted vision. She has difficulty expressing her needs. She calls out periodically, but is often unable to articulate what she wants or needs. She is sometimes understood by others when expressing herself. She sometimes understands others. The facility attempted the BIMS but the resident was unable to complete the interview.
Assessments note that the resident has experienced one fall without serious injury in the past month, no change from her previous pattern. The resident has always had some urinary incontinence, but has been incontinent more often recently. The facility has documented increased periods of daytime sleepiness over the past few months, including falling asleep during favorite activities. However, they also documented ongoing restlessness and agitation on the evening shift.

Monthly Drug Regimen Reviews: The consultant pharmacist has reviewed the resident's medications monthly. After the first 30 days, the consultant pharmacist recommended that

the team attempt a gradual dose reduction/discontinuation of the drug Seroquel (at that time, dose was 50 mg BID). The physician declined to do so and indicated that it had been started by a psychiatrist (specialist) at the hospital. Continued review of pharmacy documentation shows that eventually the dose of Seroquel was increased from 50 mg po bid to 75 mg po bid due to more frequent episodes of calling out and occasional refusals of care, particularly on the evening shift. A month ago, the consultant pharmacist again recommended a GDR. The physician declined, stating that the resident's "agitation" had increased and this was the reason for the medication and the increased dose. No documentation was found to identify whether there was an improvement in her behavior or function since the dose was increased. Nor was there any documentation to note if the resident was experiencing any adverse consequences from the medication.

Additionally, there is no mention in the MRR about:

- supporting diagnosis for continued use of Prevacid,
- Risk/benefit of oxybutynin
- Pain assessment and use of PRN acetaminophen
- Behavioral assessment and use of PRN Ativan

Digoxin levels and electrolytes have been checked every six months and are within normal limits.

Behavioral Documentation Sheets/Nursing Notes: Reflect that the resident was admitted with the diagnosis of dementia. Regarding medications, notes indicate only the Seroquel 75 mg po bid and the Ativan 0.5 mg tid prn for agitation. No documentation could be identified regarding consideration of possible causes of, or triggers for, her restlessness and what staff perceives to be "resistance to care." (This phrase has been used commonly in nursing home documentation to describe the staff member's perception when he or she is trying to accomplish a specific task and the resident may not understand what he/she is being asked to do, or the resident simply does not wish to do it.) However, there were some notes describing activities and other interventions that were attempted as part of the care plan (see below). The behavior monitoring sheets reflect many "zeros" and many other shifts where the forms are not completed. Specific behaviors are often not noted.

MAR: The MAR reflects that Mrs. Grant has received prn ativan about 4-6 times a week since the time of admission, mostly at the end of her daughter's visits and on evenings when staff are assisting with ADLs. In some cases the nurse documents "good effect;" in others there is no documentation of the result of the prn medication. In most cases, the indication for the prn use is listed as "agitation."